81

_						1	
	Psychosocial Assessment		F	PREGNANCY OUTCOME			
2. 3. 4. 5.	Poor Previous Pregnancy Experience Poor Support System Depression, Other Mental Health Issues Drugs/Alcohol/Tobacco Usage 8 9 10 11	7. Conflict/Violence in the Home 8. Unable to get Prenatal Care 9. Family has Urgent Health Needs 10. Insufficient Funds for Food 11. Difficulty Obtaining Food Stamps 12. Difficulty Enrolling in WIC 13. Child Care 14. Housing N 15. Transport 16. School Ne 17. Employme 18. Child Sup				Pregnancy Ended _ Postpartal/Family Pl Postpartal/WIC Cer Infant Certified for HealthCheck Referr Closed for Care Co	rtification WIC_ ral ordination Service
	Problems/Concerns	Date Detected	Gestational Age	Actions Taken	d/Improved?	Recipient Name	
Prenatal Care Co							Medicaid ID number
Prenatal Care Coordination Services Handbo							Agency Nam

Care Plan (Sample Format)

Appendix 13

POSTPARTUM VISITS AND INFANT CARE REFERRAL

Appendix 13 (Continued)

CONTENT OF CARE COORDINATOR	VISIT	S (Pleas	e check	the acti	ivities o	r items ı	elated t	o that v	risit.)	
ATE:										
ocation of contact: Office Visit										
Home visit										
Telephone visit										
estational age										
iscuss recipient's concerns										
ollow up on previous referrals										
ontinue screening for abuse, stress, need or mental health and social services										
EALTH PROMOTION/EDUCATION										
ontinue nutrition counseling, referral										
isks to avoid: medications, chemicals, tc.										
lonitor smoking, alcohol, drug use										
lanaging common discomforts										
larning signs in pregnancy										
romote breastfeeding										
laternal seatbelt use, infant car seat safety										
reterm labor symptom recognition										
reparation for labor/birth										
romote prenatal/parenting classes										
igns of labor where/when to go										

Appendix 13 (Continued)

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.) DATE: TRANSPORTATION ASSISTANCE Care Coordinator Checklist (page 2) Contacted county transportation Contacted HMO transportation Other, specify: **CHILD CARE ASSISTANCE** Contacted county child care assistance Other, specify: **SPECIAL COMMUNICATIONS** Contacted primary care provider Received information from primary care provider Client needed extra appointment reminders and follow up Communications with referral providers OTHER: Signature